

WASHINGTON MASSAGE NEWS

Wash. Chapter, American Association Masseurs & Masseuses at last bring
 out their first issue of the year and it's bound to be interesting. The January issue contained
 the following February Issue, 1959.

It's press time again! The month will conclude the article on the sacroiliac taken from the English magazine. We hope you liked it. If you wouldn't like more, or if you have similar subjects to share with the rest of us, just send it along.

The committee on legislation is busy getting a bill into this session of the legislature. It looks very much like the Medical people are going to go along with this one. After we committed a bill to the other things, such as electro-therapy, they seemed more inclined to accept it.

Now I would like to suggest that for those of our group who would like to make a fight for the right to use those machines and equipment of various kinds, we hold another estate meeting and see if we can agree on a defense of those rights in itself of our rights from court. This is the only way it will ever be made legal for us to use them because it is impossible to get a bill with all the things in it through the legislature with our small group.

Think it over and write in care of this paper. Better Health Salon, 5238 University Way, Seattle 5, Washington.

You will be mailed copies of the bill as soon as it is ready.

News briefs are as follows:

Mrs. Regina Williams had a bad fall in the snow. She suffered painful injuries, but is doing well, and is still on the job. Lots of luck, Jeanne...lots of courage.

John Murray is working at home for a month.

That's all for this month. We'll be with you again in March.

Art Dunbar, 5238 University Way, Seattle 5, Wash.

Part One of the following article appeared in the December issue:

A third test is to have the patient prone and use a somewhat similar device for gapping and rotation of the joint. If the patient is prone, and you are standing on the patient's right side, flex the patient's right knee and hip as high as possible again. You will, of course, have to bring the knee down below the level of the table so that you can get it up. Bring the patient close to the side of the table so as to be able to flex the knee and hip. Hold that position of flexion with your right knee against the patient's right knee, leaving your hands free to detect and palpate the sacro-iliac joint. By rocking with your knee you can rock the pelvis, and you can palpate the sacro-iliac joint. In fact, you can reinforce the movement of rocking by pressure. If you apply your fingers to the sacro-iliac joint nearest to you, the right one, your left forearm resting around the left buttocks of the patient, your right arm resting around the crest of the ilium, you are in a good position for palpation and leverage on the sacro-iliac joint. This is a good way of testing movement, but it needs a lot of practice.

A fourth test consists in having the patient prone with the legs just lying out straight as normal, and applying a vertical thrust over the apex of the sacrum. Then palpate over the sacro-iliac joint with your other thumb. This is the most difficult of the tests because of the amount of the rocking which occurred between the sacrum and the innominate, especially if there is no leverage of the leg to help you.

Those four tests will give you some idea of the range of movement and enable you to distinguish the hyper-mobile joint from the hypo-mobile one. The sacro-iliac joint can, apart from being faulty in its movements, also, be faulty in its position. In order to test this, have the patient standing or sitting and feel from behind to find the level of the posterior superior spines. I prefer to do this standing first and then to palpate the crest of the iliac to get an idea of the levels of the crest. The innomates are notoriously anomalous in shape and do not have the symmetry of some other joints or bones in the body. Whilst it is important to test the position of those body points, antero superior iliac spines, posterior superior iliac spines, symphysis pubis, crests and the ischial tuberositis, you can test them in any position you like and infer from your positioning whether there is any division of one innominate upon the sacrum or not. I do not consider that bony landmarks are of much help in diagnosing sacro-iliac lesions as the mobility tests described above. Hence, it is preferable to use mobility tests first. Now if the sacro-iliac joints can rock in a horizontal plane -- in other words, get anterior-posteriorly, and if it can rock up and down, that is, rotate around the second sacral level -- then it is possible for the two bones to be fixed in a position of rotation or position of gapping. It is our job to determine the positions as well as the range of movement. If the joint is hyper-mobile, it is unlikely that there will be faulty positioning, but if it is hypo-mobile then it can be fixed in a position of rotation, either forward or backward, and, in the old osteopathic terminology, we have an anterior innominate or a posterior innominate. The posterior superior iliac spines may be less prominent -- the

anterior innominate or more prominent - the posterior innominate - in manipulating such joints will aim to correct position as well as increase movement. Apart from those tests I propose to indicate one or two more significant clinical features of the sacro-iliac lesions to help in differentiating it from, say, the lumbo-sacral or lower lumbar joint lesions. First of all, as indicated above, women are more likely to have sacro-iliac lesions than men, and women who are pregnant or who have just had babies will have them more commonly than other women. Many back-aches date from childbirth. Backaches in such cases does not necessarily indicate sacro-iliac lesions but at least it is a pointer in the diagnosis. If the sacro-iliac is in lesion and is causing symptoms, the pain will be uni-lateral. This may seem obvious - and only a negative feature can be - but it is a point. A patient with a central backache certainly does not have a sacro-iliac lesion. If the pain is in the region of the sacro-iliac joint, there is some chance of sacro-iliac lesion, but it is by no means certain. In my early days of practice, something like 20 years ago, I was quite sure about one patient who occasionally comes to see me. She had what was to me, very osteopathically minded in those days, a posterior innominate and sacro-iliac lesion. Well, I corrected it in the appropriate manner and responded beautifully. I was well satisfied that therapeutically I was doing the right thing. But over the years she had several subsequent attacks, and later developed a sacro-iliac scoliosis which was due to an obvious disc lesion. I think I was mis-interpreting her symptoms when I first saw her. She was one of the cases which made me think very much more on lines of lumbar joints that cause more symptoms, more back troubles, than the sacral-iliacs do. Even so, there are a number of cases which are quite distinct and separate from disc lesions.

Here are one or two more pointers on how to distinguish them. The pain is unilateral. It is located in the region of the posterior-superior iliac spine or just medial to it. If there is a reference of pain, the referred pain will be in the posterior-lateral parts of the thigh and the calf. A recent book by Hackett, who has done a lot of work on anaesthetizing the sacro-iliac, ilio-lumbar and other ligaments shows to his own satisfaction anyway, that the reference of pain from sacro-iliac ligaments is into the posterior-lateral part of the thigh and calf. This is also the area of pain when nerve roots are irritated from disc prolapses. The distinguishing feature here is that sacro-iliac lesions never give rise to abnormal neurological signs. There is no area of numbness, pins and needles, or loss of power. No abnormal neurological signs arises from a sacro-iliac lesion. This gives much help in differentiation in addition to the tests described above. The type of injury is always a help. I would just mention the history. If a patient falls from a height or sits down heavily on a chair which is not there, he suffers a compression injury which is more likely to affect discs than the sacro-iliac joints. If, on the other hand, the patient has been striking at a golf ball with the feet fixed, and has missed the ball or struck the ground instead, then the jar is a twisting one. It is a torsional movement. The pelvis is pretty well fixed; the innomates are fixed by the feet. And in a twisting movement of the torso the spine as a whole moves the sacrum on the innomates.

This is much more likely to give rise to a sprain of the sacro-iliac joints. In other words, tornal injuries more commonly cause sacro-iliac lesions, and compression injuries cause disc lesions. The tenderness of the sacro-iliac lesion is local to the sacro-iliac joint and just medial to it. But another place where tenderness is found is over the sacro-tuberous ligament. The sacro-tuberous ligament goes from the ischial tuberosity upwards and medially to the apex of the sacrum. It is very easy to palpate it, so long as the patient relaxes the glutei. This ligament is often on tension especially in the posterior innominate, that is to say, where there has been rotation of the ilium backwards with a forward movement of the ischial tuberosity relative to the sacrum. There are the signs and symptoms found in mechanical faults occurring in the sacro-iliac joint. It is now necessary to consider treatment. The treatment of a relaxed or hypermobile sacro-iliac joint is not manipulation. It is support and exercises and erector spinal strengthening exercises. Obviously, as we have said before, we do not want to overstretch an already elongated series of ligaments. Therefore we shall support it. The type of support I prefer is stronger type of corset with a reinforced sacro-iliac band so that there is a restriction movement in the lumbar spine while the reinforcing sacro-iliac band, hold tightly round the pelvis just below the antero superior iliac spines, provides support where it is needed. It is most important that it should hold the pelvis together. The treatment of the restricted joint, if there is fault in the joint and it is not merely restricted because of increasing age, is a question of manipulation. Manipulating the sacro-iliac joint can be done by articulating it or by a specific thrust. With the patient lying on the back, supposing it is desirable to articulate the sacro-iliac joint on the right, stand on the patients right side, flex the knee and hip with the right arm around it, grasping and rocking it as in the testing movement. Circumduct the hip and generally stretch and mobilize. That is a rather non-specific a passive sort of movement. In a similar way, the testing position described above can be used, with the patient prone. The knee is brought up underneath the side of the table, rocking again, gapping and rocking. All this is good but not particularly specific. There are some specific movements which I will now try to describe to you. The first is with the patient prone. Supposing it is desired to mobilize the right sacro-iliac joint. Stand on the patients left side and lift his right leg by putting your right hand under his thigh. Lift the thigh in an extension. The idea is to create a tornal effect by using the ligament of the quadriceps and rectus-femoris to pull on the anterior superior iliac spine. Use that as additional leverage. While lifting with your right hand, use the heel of the left hand to apply direct to the posterior superior iliac spine. Make a thrust simultaneously with extension of the hip directly over the superior iliac spine. When the movement is successful, you hear and feel a little click... a very satisfying little click. Then you know you have moved the joint. You can also rock the sacro-iliac applying a thrust with your left hand over the right posterior-superior and applying a thrust to the apex of the sacrum with your right hand. Use a springing thrusting movement with the idea of gapping it. Supposing we wish to move the sacro-iliac joint with the patient on the side. Taking the right sacro-iliac as an example again, ask the patient to lie on the left side. Face the patient and ask him to bring the upper leg, the right leg that is, up a little and let it hang over the side of the plinth. Now position that leg in such a way as to feel tension in the sacro-iliac joint.

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itself. So that, with a little more flexion, the tension moves away. Palpate all the time when the tension is occurring in the sacro-iliac area and the amount of flexion and the amount of dangling of the leg over the side of the table is dependent upon your sense of touch and your sense of tissue tension. Here then we have a patient lying on the left side with the uppermost leg, the right leg, over the side of the table. The next step is to rotate the torso down to the sacro-iliac, right down to the sacrum anyway. In order to do so, pull on the patient's lower arm, the left arm, so that the body is rotated. The shoulder pulled forward on the left and pushed backward on the right. It is important as the arm is pulled forward and the trunk rotated backwards to feel with the fingers how far tension is being created. The whole of the lumbar spine should become locked so that it acts as a rigid level right through to the sacrum. The positioning of the patient is very important. The leg is already in a position where there is some tension. Pull the torso round so that all the slack is taken out of those joints. Next, hold the shoulder back with the right hand and apply the heel of the left hand to the posterior superior iliac spine. With the thrust towards the patient's anterior superior spine, make sure your elbow is over the patient in order to get the thrust on to the posterior superior iliac spine. The tensions are ready. The position is right. Then it is only a question of exerting a short sharp additional thrust in the plane of the auricular facets and you will frequently feel a click under your finger in the sacro-iliac joint itself.

Conclusion